DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00163 (11/10)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTI-OBESITY DRUGS

Instructions: Type or print clearly. Before completing this form, read Prior Authorization Drug Attachment for Anti-Obesity Drugs Completion Instructions, F-00163A.

Providers may call the Drug Authorization and Policy Override Center at (800) 947-9627 with questions.

SECTION I — MEMBER AND PROVIDER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member
4. Name — Prescriber	5. National Provider Identifier (NPI) — Prescriber
6. Address — Prescriber (Street, City, State, ZIP+4 Code)	7. Telephone Number — Prescriber
8. Name — Billing Provider	9. NPI — Billing Provider

SECTION II — PRESCRIPTION INFORMATION

10. Drug Name (Check only one.)

❑ Xenical® (orlistat) ❑ benzphetamine ❑ diethylpropion ❑ phentermine ❑ phendimetrazine

11. Drug Strength	12. Date Prescription Written
13. Directions for Use	14. Refills

SECTION III — CLINICAL INFORMATION

15. Diagnosis Code and Description

16. Height — Member (Inches)	17. Weight — Member (Pounds)
18. Date Member's Weight Was Measured	19. Body Mass Index (BMI) — Member (lb / in^2)
20. Goal Weight — Member (Pounds)	$BMI = \frac{703 \times (\text{weight in pounds})}{(\text{height in inches})^2}$

For an initial drug request, the provider should complete Section IV A and Section IV B. For a renewal drug request, the provider should complete Section IV A.

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS

21. Is the member pregnant or nursing?	❑ Yes	❑ No
22. Does the member have a history of an eating disorder (e.g., anorexia, bulimia)?	❑ Yes	❑ No

Continued

DT-PA085-085

SECTION IV A — INITIAL AND RENEWAL COVERAGE REQUIREMENTS (Continued)

23. Medication Contraindications (Check either A or B and answer the questions that follow.)

A. ❑ Xenical® (orlistat).

❑ Does the member have chronic malabsorption syndrome?	❑ Yes	❑ No
❑ Does the member have cholestasis?	❑ Yes	❑ No

B. ❑ Benzphetamine, phendimetrazine, phentermine, or diethylpropion.

❑ Does the member have glaucoma?	❑ Yes	❑ No
❑ Does the member have hyperthyroidism?	❑ Yes	❑ No
❑ Does the member have advanced arteriosclerosis?	❑ Yes	❑ No
❑ Does the member have a history of drug abuse or misuse?	❑ Yes	❑ No
❑ Does the member have uncontrolled hypertension?	❑ Yes	❑ No
❑ Is the member hypersensitive to any sympathomimetic amines?	❑ Yes	❑ No

SECTION IV B — INITIAL COVERAGE REQUIREMENTS

24. Body Mass Index Requirements (Check A or B.)

A. ❑ The member's BMI is greater than or equal to 30.

B. ❑ The member's BMI is greater than or equal to 27 but less than 30 with two or more of the following risk factors. Check the member's current risk factors.

- ❑ Coronary Heart Disease.
- ❑ Dyslipidemia.
- ❑ Hypertension.
- ❑ Sleep Apnea.
- ❑ Type II Diabetes Mellitus.

25. Has the member participated in a weight loss treatment plan (e.g., nutritional counseling, an exercise regimen, a calorie-restricted diet) in the past six months and will member continue to follow this treatment plan while taking an anti-obesity drug? ❑ Yes ❑ No

If yes, describe the treatment plan in the space provided.

SECTION V — AUTHORIZED SIGNATURE

26. **SIGNATURE** — Prescriber	27. Date Signed — Prescriber

SECTION VI — ADDITIONAL INFORMATION

28. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

SECTION VII — FOR INTERNAL USE ONLY

- ❑ Initial request.
- ❑ Renewal request (Xenical®).
- ❑ Renewal request (benzphetamine, diethylpropion, phendimetrazine, or phentermine).